DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
Cambridge Building, 263 Chapman Rd, Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center

DATE SURVEY COMPLETED: September 12, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from September 6, 2022 through September 12, 2022. The deficiencies contained in this report are based on observations, interviews, reviews of residents clinical records and review of other facility documentation. The facility census the first day of the survey was one-hundred and one (101). The survey sample totaled twenty (20) residents.	Cross reference the Plan of Correction found in the Federal Report. A. Residents of Seaford Center on 8/24/2022 were not adversely impacted by the facility failing to provide staffing at a level of at least 3.28 hours of direct care per patient day.\	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**	B. All residents within the facility had the potential to be impacted by the deficient practice.	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by the following:** Cross refer to CMS 2567-L survey completed September 12, 2022: F580, F584, F684, F686, F689 and F756.	C. A root cause analysis was completed on 9/13/2022, which revealed that the facility had insufficient staff on the dates cited due to CAN and Nurse call-offs. The Administrator/designee will review scheduled hours per patient day (HPPD) on a daily basis beginning 9/13/2022 to verify facility's compliance with the state required staffing levels.	
16 Del. Code, 1162 Nursing Staffing:	**(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide**		

Provider's Signature Lucy Hollister Title Administrator Date 9/29/22

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	3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** RN/LPN — CNA* Day — 1 nurse per 15 res. — 1 aide per 8 res. Evening — 1:23 — 1:10 Night — 1:40 — 1:20 * or RN, LPN, or NAIT serving as a CNA. (g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week. A staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on September 12, 2022. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that for one day out fourteen (14) days, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following: 8/24/22 PPD = 3.21 9/14/22 9:42 AM – An email was sent to E1 (NHA) of above findings.	If staffing is projected to be below 3.28 PPD, the Director of Nursing/designee will contact staff to report to work, offering incentives if necessary. The facility has been able to hire additional Nursing Management staff and they are on-call to work if other staff cannot be found. The Facility will continue to use agency staff to supplement and maintain the staffing level of 3.28. D. The Administrator/designee will review reports on daily PPD to verify that the facility does not bo below 3.28 hours PPD. Reports will be review by the QAPI Committee on a monthly basis for 3 months or until 100% compliance is achieved.	10/12/2022

Provider's Signature Teresa Hollinger Title Administrator Date 9/29/22

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	9/14/22 11:32 AM – A telephone interview with E1 (NHA) confirmed receipt of the above e-mail sent on 9/14/22 and no additional information was received. The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

Provider's Signature Jessey Hollinger Title Administrator Date 9/29/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 09/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from September 6, 2022 through September 12, 2022. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records and review of other facility documentation. The facility census the first day of the survey was one-hundred and one (101). The survey sample totaled twenty (20) residents. Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Bed mobility - how resident moves to and fromlying position, turns side to side and positions body while in bed; Bilateral - affecting both sides; CNA - Certified Nursing Assistant; CRN - Clinical Resourse Nurse; Distal - situated away from the center of the body; DON - Director of Nursing; Emesis - vomit; Femur - thigh bone; Hoyer Lift - sling-type hydrolic lift; MDS - Minimun data set - standardized assessment forms used in nursing homes; NHA - Nursing Home Administrator; NP - Nurse Practicioner; Periwound - area of skin surrounding a wound; Stages of pressure ulcers (categorization system used to describe the severity of PUs): Stage I (1) - a reddened area of intact skin usually over a boney prominence, that when pressed does not turn white. This is a sign that a PU is starting to develop. Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/28/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 irritated. Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin. Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints. Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed). Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue. RN - Registered Nurse; SN - Skilled Nurse; TAR - treatment administration record; Wt - Weight.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		10/12/22

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F 580	Continued From page 2 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R2) out of three residents reviewed for pressure ulcers and	F 580	A. Unable to correct as R2 is deceased. B. The Director of Nursing/Designee completed an audit of all current residents	

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F 580	Continued From page 3 nutrition the facility failed to ensure prompt notification of changes. For R2 the facility failed to consult the physician regarding a significant weight loss, failed to notify the responsible party of the significant weight loss and the development of pressure ulcers. Findings include: The facility policy on weights last updated 6/1/21 indicated, "Notify the physician and dietitian of significant weight changes; the licensed nurse will notify the family/healthcare decision maker of the weight change and dietitian recommendations. Family notification will be documented." The facility policy on skin integrity and wound care management last updated 9/1/22 indicated, notify physician to obtain orders. Notify patient, representative of plan of care. Review of R2's clinical record revealed: 4/25/22- A significant change MDS assessment documented R2 as having weight loss and risk of pressure ulcers but no actual pressure ulcers. 4/26/22 - A nutritional assessment documented R2 as having a weight of 135 with a history of 11.7% loss in 6 months, and loss of 8.2% in 3 months. 2/4/22 157.4 Lbs 3/21/22 147.0 Lbs 4/8/22 140.4 Lbs 4/21/22 135.0 Lbs 4/28/22 untimed - Review of the physicians progress note lacked evidence that R2's physician was aware of or consulted about the residents significant weight loss.	F 580	with skin breakdown and significant weight loss to ensure medical provider and family notifications have been completed. All residents identified their responsible parties and medical providers have been notified of any skin breakdown or significant weight loss. All current residents have the potential to be affected by the alleged deficient practice. C. Root cause analysis was completed on 9/09/2022 and determined that residents with alterations in skin integrity did not consistently have documentation indicating that the medical provider and responsible parties were promptly made aware of changes in skin integrity. The Nurse Practice Educator/Designee will provide additional education on policy NSG122 Change in Condition Notification with an emphasis on promptly notifying responsible parties and medical providers of changes in skin integrity to all current licensed nursing staff which will be completed by 10/12/2022. Root cause analysis completed on 9/09/2022 and determined that residents with significant weight loss did not consistently have documentation indicating that the medical provider and responsible parties were promptly made aware of changes in condition. The Nurse Practice Educator/Designee will provide additional education on policy NSG122 Change in Condition Notification with an emphasis on promptly notifying responsible parties and medical providers of significant changes in weights to all current licensed nursing staff which will be completed by 10/12/2022.	

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F 580	Continued From page 4 5/5/22 untimed - Review of the physicians progress note lacked evidence that R2's physician was aware of or consulted about the significant weight loss. 5/7/22 9:25 AM - A nutrition note documented, "Stage II [PU] sacrum- (4/29/22). Resident presents with significant weight loss and new onset of skin breakdown. Intakes have declined over past month." The nutritional assessment lacked evidence that R2's responsible party and physician were made aware of the significant weight loss. 5/7/22 9:37 AM - A care plan evaluation note documented, R2 as having "Significant weight loss...New onset Stage II to sacrum." Review of R2's clinical record lacked evidence that R2's responsible party and physician were made aware of the significant weight loss and that R2's responsible party was notified of the development of a stage II pressure ulcer to R2's sacrum. 5/9/22 10:00 AM - A note in R2's clinical record documented, "Nursing observations, evaluation, and recommendations are: SN [skilled nursing] evaluated all wounds present to patient, including patient's sacral wound, DTI to patient's right posterior thigh & Stage I to patients's right heel. SN discussed treatment options with [physician] who was in agreement with the new treatment orders." The note lacked evidence that R2's responsible party was notified of the development of additional pressure areas on R2's body. 5/10/22 untimed - A physicians progress note documented, "Resident, staff did not report any change in diet". Review of the physicians	F 580	D. The Director of Nursing/Designee will complete an audit (Attachment A) of residents who with skin breakdown to ensure prompt notification of providers and responsible parties has been completed twice weekly for 3 weeks until compliance is achieved, then weekly for 3 weeks until 100% compliance achieved, and then monthly for 3 months until 100% compliance is achieved to determine if NSG122 policy has been followed and the change in condition was reported promptly to medical provider and responsible party. Results of audits will be presented to the QAPI committee for review and any follow up. The Director of Nursing/Designee will complete an audit (Attachment B) of residents with significant weight loss to ensure prompt notification of providers and responsible representatives has been completed twice weekly for 3 weeks until compliance is achieved, then weekly for 3 weeks until 100% compliance achieved, and then monthly for 3 months until 100% compliance is achieved to determine if NSG122 policy has been followed and the change in condition was reported promptly to medical provider and responsible party. Results of audits will be presented to the QAPI committee for review and any follow up.	

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F 580	Continued From page 5 progress note lacked evidence that R2's physician was aware of the significant weight loss. 5/11/22 11:33 AM - A care plan meeting was held for R2. In attendance was R2's physician. The clinical record lacked evidence that R2's physician was made aware of R2's weight loss prior to this care plan meeting. R2's responsible party did not attend the care plan meeting, the clinical record lacked evidence R2's responsible party was made aware of the significant weight loss, and the development of pressure ulcers. During an interview on 9/7/22 at 8:58 AM, CG1,(R2's responsible party) stated, "[R2] looked like she had lost weight then we saw this huge pressure ulcer that no one even told us about until it was that big. I was blindsided." During an interview on 9/9/22 at 12:20 PM E3 (CRN) confirmed that staff were expected to make notifications about weight loss and development of pressure ulcers in accordance with facility policy. During an interview on 9/9/22 at 2:23 PM E13 (NP) stated, "I expect to be notified based on following the procedure the facility has for the nursing staff. " Findings were reviewed during the exit conference on 9/12/22 at 2:45 PM with E1 (NHA), E2 (DON) and E3 (CRN).	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		10/12/22

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F 584	Continued From page 6 The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F 584		

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F 584	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on random observations and interview on two out of two units it was determined that the facility failed to provide a safe, clean and homelike environment for residents. Findings include: 9/7/22 2:20 PM - During an interview, E11 (LPN) confirmed that there are multiple areas throughout the facility that need repair. She stated that "ceiling tiles are stained, some are loose and the vents are dusty." During a tour of the facility with E9 (Maintenance Supervisor) and E10 (Maintenance Assistant) on 9/8/22 at 10:00 AM the following observations were indentified : Room 102 - Baseboard peeled away from the wall exposing a black discolored wall and beneath air conditioning unit. Room 103 - Grayish spots on the ceiling tiles above the entrance to the bathroom and adjacent to the sprinkler head. Room 104 - Baseboard peeled away from the wall exposing a black discolored wall beneath air conditioning unit. Room 106 - Raised rippled area in the center of the bathroom floor. Room 107 - Grayish/brown spots on the ceiling tile just above the entrance. Room 109 - Grayish/brown spots on the ceiling tile just above the entrance and inside the bathroom the wall beside the entrance there was no baseboard and pieces of plaster had fallen off. Room 123 - Black substance resembling dirt and dust inside the air conditioning vent. Room 205 - Baseboard peeled away from the	F 584	A. A specific resident(s) was not cited. B. The Maintenance Director/designee completed an audit on 9/27/2022 of all resident room and hallways to identify corrections required regarding stained ceiling tile, baseboard issues, vinyl floor buckling, air conditioner dirty/dusty vents and filters, dirty air vents, and stained carpets. All current residents have the potential to be affected by the alleged deficient practice. C. Root cause analysis identified routine preventative maintenance was not consistently performed related to a change of the maintenance staff and a lapse of time during this staffing change. The Senior Maintenance Director will re-educate staff on the preventative maintenance program. D. The Maintenance Director will complete a random audit (Attachment I) to ensure that new areas to address are identified and corrected. Audits will be weekly x 3 weeks or until 100% compliance is achieved then monthly x 3 months until 100% compliance is achieved. Results of the audits will be presented to the QAPI Committee for review and any follow-up needed.	

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F 584	Continued From page 8 wall exposing a black discolored wall and beneath air conditioning unit. Room 234 - Bathroom ceiling fan/vent full of dust and a small section of the baseboard on the sink and toilet wall was peeled away from the wall. 9/8/22 11:10 AM - During an interview following the facility tour E9 confirmed the above findings stating that the roof had been leaking which caused moisture damage inside the facility. In addition, the water had been dripping down the outside walls and the crawl space became saturated. The repairs to the roof and the crawl space had been completed. 9/12/22 2:40 PM - A maintenance logbook documented the last time air conditioning units located in all resident rooms were cleaned and/or filters replaced was five months ago on 3/31/22. 9/12/22 3:25 PM - During an interview, E9 comfirmed that the last time the air conditioning units were inspected was on 3/31/22. 9/12/22 2:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (Corporate Resource Nurse).	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		10/12/22

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F 684	Continued From page 9 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R2) out of three residents reviewed for falls the facility failed to ensure completion of post fall neurological assessments for an unwitnessed fall. Findings include: The facility policy on Neurological Evaluations last updated June 1, 2021 indicated, "Neurological evaluation will be performed as indicated or ordered. When a patient sustains an injury to the head or face and/or has an unwitnessed fall. Neurological evaluation will be performed: every 15 minutes for two hours then, every 30 minutes for two hours then, every 60 minutes for four hours then, every eight hours until at least 72 hours has elapsed. To monitor for neurological compromise." Review of R2's clinical record revealed: 4/25/22 - A fall incident report documented that R2 was "found by a CNA next to her bed on her knees with upper half of body in bed. Resident stated she was trying to help someone. Resident has redness to bilateral knees. Resident able to move upper and lower extremities without issue. Resident complained of pain to knees, pain medication given per orders. Neurological checks started". Review of R2's post fall neurological assessment sheet revealed the absence of completion of neurological assessments on 4/25/22 from 6:20 AM through 7:05 AM during the second hour of the first two hours after the fall. It was	F 684	A. Unable to correct as R2 is deceased. B. The Director of Nursing/Designee completed an audit on 9/09/2022 of the last three days of incident reports that included all residents who had an unwitnessed fall and/or who sustained an injury to their head or face and required neurological assessments to ensure initiation and completion of neurological assessments. C. Root cause analysis was completed on 9/09/2022 and it was determined that licensed nursing staff did not always wake sleeping residents up to complete neurological assessments and did not have complete understanding of the necessity of a complete neurological assessment per policy NSG204 Neurological Evaluation. The Nurse Practice Educator/Designee will complete education with all licensed nursing staff on NSG204 Neurological Evaluation with a focus on completing the neurological assessment regardless of if a resident is sleeping or not which will be completed by 10/12/2022. D. The Director of Nursing/Designee will complete an audit (Attachment C) of all incident incident reports that included an injury to the head or face and/or who had an unwitnessed fall to ensure neurological assessments have been completed per policy NSG204 weekly for 4 weeks or until 100% compliance is achieved, then monthly for 3 months or until 100% compliance is achieved. Results of audits	

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F 684	Continued From page 10 documented that R2 was "sleeping". Additional absences of completion of post fall neurological assessments occurred on 4/26/22 at 9:00 PM and 4/27/22 5:00 AM, the entry spaces were blank. During an interview on 9/9/22 at 12:20 PM E3 (CRN) confirmed the finding. E3 stated she was unaware why the neurological assessments were not completed. Findings were reviewed during the exit conference on 9/12/22 at 2:45 PM with E1 (NHA), E2 (DON) and E3 (CRN).	F 684	will be presented to the QAPI committee for review and any follow up.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R2, R1 and R8) out of three sampled residents reviewed for pressure ulcer (PU), the facility failed to ensure PU care, treatment and services, consistent with	F 686	A. Unable to correct R8, R2 as they are deceased. Unable to correct R1 as the facility failed to complete weekly skin assessments and weekly wound assessments	10/12/22

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F 686	Continued From page 11 professional standards of practice were provided to the residents. For R2, the facility failed to complete initial wound assessments, weekly wound assessments and ordered wound treatments. For R8 and R1 the facility failed to complete weekly skin assessments. Findings include: The facility policy on skin integrity and wound care management last updated 9/1/22 indicated, "The licensed nurse will perform and document weekly skin inspection on all newly admitted/readmitted patients ... Complete wound evaluation upon admission/readmission, new in-house acquired, weekly and with unanticipated decline in wounds. 1. Review of R2's clinical record revealed: 12/8/21 - R2's care plans related to risk of pressure ulcers and actual skin break down included interventions to complete weekly skin assessments and for weekly wound assessments to include measurements and description. 4/25/22 - A significant change MDS assessment documented R2 as at risk for development of pressure ulcers but having no actual pressure ulcers. 4/26/22 - R2 was assessed as at moderate risk for development of pressure ulcers. 4/29/22 - A physicians order was written for a treatment to R2's sacrum. The order did not describe the stage of the sacral wound. 5/4/22 - An initial wound care evaluation sheet documented R2 as having a DTI to the sacrum.	F 686	B. The Director of Nursing/Designee completed an audit of all current residents in the facility on 9/13/2022 to ensure weekly skin assessments have been completed. The Director of Nursing/Designee completed an audit of all residents with skin breakdown to ensure that weekly wound assessments have been completed. The Director of Nursing/Designee completed an audit of all residents with new or worsening wounds to ensure that initial wound assessments had been completed. All current residents in the facility and all current residents with skin breakdown have the potential to be affected by the alleged deficient practice. C. Root cause analysis was completed on 9/13/2022 and determined that not all current residents in the facility received weekly skin assessments and current residents with skin breakdown did not receive weekly wound assessments per facility policy NSG236 Skin Integrity and Wound Management. The Nurse Practice Educator/Designee will re-educate all current licensed nurses on NSG236 Skin Integrity and Wound Management policy which will be completed by 10/12/2022. D. The Director of Nursing/Designee will complete an audit (Attachment D) of all current residents to ensure weekly skin assessments have been completed twice weekly for 3 weeks or until 100% compliance is achieved, then weekly for 3 weeks or until 100% compliance is achieved, and then monthly for 3 months until 100% compliance is achieved. Results of the audit will be presented to	

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F 686	Continued From page 12 The facility was unable to locate any wound care evaluation documentation for R2's sacral wound prior to 5/4, despite the treatment order on 4/29 for a sacral wound. 5/7/22 9:25 AM - A nutrition note documented, "Stage II [PU] sacrum- (4/29/22). Resident presents with significant weight loss and new onset of skin breakdown." 5/9/22 10:00 AM - A note in R2's clinical record documented, "Nursing observations, evaluation, and recommendations are: SN[skilled nursing] evaluated all wounds present to patient, including patient's sacral wound, DTI to patient's right posterior thigh & Stage I to patients's right heel. SN discussed treatment options with [physician] who was in agreement with the new treatment orders." Review of R2's clinical record lacked evidence of wound care assessments for R2's newly developed pressure ulcers to the thigh and heel. 5/10/22 11:15 AM - An incident report in R2's clinical record documented, "Patients wound progressed from a stage II pressure ulcer to an unstageable pressure ulcer to her sacral area. Patients pressure ulcer was evaluated by this nurse and NP today and that determination was made at evaluation...Patient is noted to have a DTI to her right proximal posterior thigh and a DTI to her right heel." 5/10/22 11:30 AM - A note in R2's clinical record documented, "General late entry note: Patient was evaluated by this nurse on 5/9/22 and it was noted that the patient's wound had a foul odor present. When this nurse assessed area to patient's sacrum it was noted to now be	F 686	the QAPI committee for review. The Director of Nursing/Designee will complete an audit (Attachment E) of all residents with skin breakdown to ensure weekly wound assessments have been completed weekly and that any new or worsening wounds received initial wound assessment for 4 weeks or until 100% compliance is achieved, then twice monthly for 2 months or until 100% compliance is achieved, then monthly for 2 months or until 100% compliance is achieved. Results of the audit will be presented to the QAPI committee for review and any follow up.	

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F 686	Continued From page 13 unstageable and the periwound was noted to be red. The wound was then evaluated by this nurse & NP on 5/10, an antibiotic was ordered for wound infection." Review of R2's clinical record revealed the absence of weekly skin assessments completed one week in January, two weeks in February, two weeks in March and after 4/7/22 there were no weekly skin assessments documented as completed; R2 expired on 5/15/22. May 2022 - Review of R2's TAR indicated an absence of documentation for the completion of the Tuesday/Friday treatment to R2's sacral wound on 5/3 and the daily treatment on 5/12. During an interview on 9/9/22 at 12:20 PM, E3 (CRN) confirmed the above findings. E3 was unable to explain the lack of assessments regarding R2's wounds. 2. Review of R1's clinical record revealed: 4/22/21 - R1's care plan for risk of skin breakdown included an intervention to perform weekly skin checks and weekly wound assessments to include measurements and description. 4/6/22 - A skin integrity report documented a new stage II to R1's sacrum. Review of R1's clinical record lacked evidence of weekly skin checks completed between 6/30/22 and 7/16/22. Review of R1's wound care notes for a pressure ulcer to the sacrum lacked evidence of weekly	F 686		

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F 686	Continued From page 14 assessments between 6/21/22 and 7/4/22. During an interview on 9/9/22 at 12:20 PM, E3 (CRN) confirmed the above findings. E3 was unable to explain the lack of assessment regarding R1's wounds. During an interview on 9/9/22 at 2:23 PM, E13 (NP) stated, "I expect to staff to follow orders and policy, including any assessments etc." 3. Review of R8's clinical record revealed: 2/4/22 - R8 was assessed as high risk for pressure ulcers. 2/5/22 - A care plan for risk of pressure ulcers was created with interventions to perform weekly skin checks by the nurse. Review of R8's weekly skin checks revealed a lack of evidence that skin checks were completed from 4/7 through 4/21 when R8 expired. During an interview on 9/9/22 at 3:23 PM E3 (CRN) confirmed the absence of the skin checks. Findings were reviewed during the exit conference on 9/12/22 at 2:45 PM with E1 (NHA), E2 (DON) and E3 (CRN).	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/12/22

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F 689	Continued From page 15 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined for one (R8) out of three residents reviewed for accidents, the facility failed to ensure that R8 was returned to bed from a fall to the floor using the required Hoyer (hydraulic) lift. Findings include: Review of R8's clinical records revealed the following: Review of the facility policy on Safe Resident Handling/Transfer Equipment dated 1/1/13 revised 10/1/21, documented, "...The Total Lift will be used as the primary intervention for dependent lifting, transferring and repositioning ... The Total Lift is used for those patients who are dependent, non - weight bearing or have inconsistent weight bearing...The total lift will be used to lift patients/residents off the floor, unless contraindicated." 2/8/19 - R8 was admitted to the facility. 10/7/19 (revised on 2/17/21) - R8 was care planned to require assistance and was dependent for mobility related to general weakness. 7/17/21 - A facility form titled, "Lift Transfer Reposition" documented that R8 was not able to transfer independently, was not able to bear weight and that R8 required TOTAL LIFT (also known as a full body lift that takes the whole weight of a person when transferring from one place to another; and often called by the brand	F 689	A. Unable to correct R8 is deceased B. All current residents have the potential to be affected by alleged deficient practice. C. The root cause analysis was completed on 9/09/2022 determined not all nursing staff had a clear understanding of safe resident handling policy and procedures post resident fall. The Nurse Practice Educator/designee will re-educate all current nursing staff on policy NSG234 Safe Resident Handling with a focus on safe resident handling post resident fall which will be completed by 10/12/2022. D. Director of Nursing/Designee will audit (Attachment G) all falls to ensure the resident was transferred off the floor with mechanical lift when indicated. Audits will be completed twice a week x 3 weeks or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 3 months until 100% of compliance is achieved. Results of the audits will be presented to the QAPI committee for review and any follow up needed.	

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F 689	Continued From page 16 name, "Hoyer") requiring two person staff assist. Review of R8's Lift Transfer Reposition assessments from 2/8/19 through 4/17/22 revealed that R8 required the use of a total lift for transfers. Review of R8's ADL (Activities of Daily Living) care plan lacked evidence of R8's transfer status requiring total lift. 8/19/21 - A Quarterly MDS assessment documented that R8 required a two person extensive staff assist for bed mobility and transfer and had one fall with no injury since the prior assessment. 10/2/21 6:25 AM - A nurse progress note documented that, "Resident rolled out of bed. Bed in low position ...Staff helped me get resident back into bed ...". 10/2/21 - A written statement by E6 (CNA) revealed that she was "asked to assist getting the patient back into bed." 10/7/21 - An IDT (Interdisciplinaty Team) Therapy Screen from Rehab documented that, "... Patient rolled out of bed (bed was in low position). The patient is dependent (Hoyer) for all mobility tasks at baseline ...". 10/10/21 10:28 PM - A nurse note documented that the R8's x-ray results revealed left femur fracture and that the on call physician ordered R8 to be transferred to the hospital for treatment. 10/13/21 3:10 PM - E4's (RN Unit Manager) telephone interview with E7 (LPN) documented,	F 689		

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F 689	Continued From page 17 "... She (E7) also stated that she helped to physically lift the resident to the bed with the assistance of the other two aides on the unit, E5 (CNA) and E6 (CNA)...". 10/13/21 3:19 PM - E4's telephone interview with E5 documented, "...He (E5) stated that the resident was physically lifted to the bed while it was in the lowest position. The nurse and other aide on the unit helped to get resident back into bed...". Review of R8's October 2021 CNA flowsheet lacked evidence on how to transfer R8. 9/12/22 10:40 AM - In an interview, E3 (Corporate Resource Nurse) stated, "This is a no lift facility". E3 further confirmed that R8 was dependent and needed 2 person staff assist with Hoyer lift for transfer. The facility failed to ensure that R8 was returned to bed after falling to the floor with the use of a Hoyer lift. R8 was a totally dependent two person staff assist who required a Hoyer lift for transfer. 9/12/22 12:35 PM - Findings were discussed with E3. 9/12/22 2:45 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON) and E3 (Corporate Resource Nurse).	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		10/12/22

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F 756	Continued From page 18 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that pharmacy recommendations were reviewed by a	F 756	A. Unable to correct. R11 pharmacy recommendation reviewed by MD on 8/12/2022 and Vitamin C was	

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F 756	Continued From page 19 Physician for one (R11) out of three residents sampled for medication reviews. Findings include: Review of R11's clinical record revealed: The facility policy for Medication Regimen Review (MRR) last updated January 2022, indicated, "The pharmacist will address copies of residents MRR's to the DON and/or the attending and to the Medical Director. Facility staff should ensure that the attending physician, Medical Director, and DON are provided with copies of the MRR's. Facility should encourage physician/prescribe or other responsible parties receiving the MRR and the DON to act upon the recommendation contained in the MRR". 6/6/22 - A pharmacy review was completed that documented a recommendation to, "Please consider discontinuing vitamin C". The recommendation was unsigned. The facility was unable to provide evidence that a Physician reviewed this recommendation. 8/9/22 - A pharmacy review was completed that documented a recommendation to "Please reevaluate the continued use of antidepressant and reduce the dose of antidepressant as follows with the end goal of discontinuation." The recommendation was unsigned. The facility was unable to provide evidence that a Physician reviewed or acted on this recommendation. During an interview on 9/7/22 at 11:51 AM, E3 (CRN) confirmed the findings. Findings were reviewed during the exit conference on 9/12/22 at 2:45 PM with E1 (NHA), E2 (DON) and E3 (CRN).	F 756	discontinued. Psychiatry services consulted to review psychotropic/therapeutic medication use on 8/16/2022 psychotropic/therapeutic medication use evaluation was completed which indicated gradual dose reduction was not recommended. B. All current residents have the potential to be affected by alleged deficient practice. Director of Nursing/Designee completed an audit of all pharmacy recommendations from the last 30 days to ensure the facility acted on the recommendations and the physician reviewed. C. A root cause analysis was completed on 9/08/2022 which determined the facility did not have a consistent process to ensure the facility acted on the recommendations timely and the physician reviewed. Nurse Practice Educator/Designee will re-educate all current licensed nursing staff on policy 9.1 medication review and the newly established process to ensure the facility is acting timely and physician is reviewing all pharmacy recommendations which will be completed by 10/12/2022. D. The Director of Nursing/Designee will audit (Attachment H) all pharmacy recommendations to ensure all recommendations have been acted upon timely by the facility and the physician has reviewed. Audits will be weekly x 3 weeks or until 100% compliance is achieved then monthly x 3 or until 100% compliance is received. Results of the audits will be presented to the QAPI committee for review and any follow up needed	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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